STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445302	A. BUILDING _____ B. WING _____	03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ELIZABETHTON	1641 HIGHWAY 19E ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician of a	F 157	What corrective actions will be accomplished For those residents found to have been affected by the deficient practice: a) On 03/19/12, the charge nurse notified resident #12's physician of the resident's change in condition, and Vic's Vapor Rub was ordered. b) Charge Nurse was educated by the staff development coordinator on 03/19/12 on physician notification of a resident's change in condition. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a) All facility residents have the potential to be affected by this practice. b) On 3/20/12, all residents were assessed by nursing administration for changes in condition and for appropriate physician notification. All residents were addressed appropriately. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) On 03/20/12, the staff development coordinator initiated education with licensed nurses on the facility's policy and procedure for "Notification of Changes in Status". b) On 04/18/12 and on 04/20/12, all nurses will be educated on the facility's "Notification of Changes in Status". c) "Notification of Changes in Status" will also be included in the Orientation packet provided to newly hired licensed nursing personnel beginning 03/20/12.	5/5/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer C Solomon, MA | TITLE: Executive Director | (X6) DATE: 4/2/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 change in condition for one resident (#12) of twenty-five residents reviewed. The findings included: Resident #12 was admitted to the facility on August 30, 2008, with diagnoses including History of Pulmonary Embolism, Edema, Depressive Disorder, and Anxiety State. Medical record review of the resident Minimum Data Set (MDS) dated December 19, 2011, revealed a Brief Interview for Mental Status (BIMS) score of fourteen which indicates a cognitively intact resident. Continued review of the MDS revealed the resident was always understood and always understands. Observation and interview on March 19, 2012, at 10:22 a.m., in the resident's room, revealed the resident sitting on the bed. Continued observation and interview revealed the resident with audible congestion and had requested vapor rub (medication for congestion) on March 18, 2012, from Licensed Practical Nurse (LPN) #5. Interview with the resident and LPN #2 on March 19, 2012, at 3:40 p.m., in the resident's room, confirmed the Physician had not been informed of the congestion or request of medication.	F 157	How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: a) The director of nursing, assistant director of nursing, and/or the nursing supervisor will audit the 24hr report daily and receive report from the charge nurses to ensure proper procedures, intervention, and actions were initiated and/or completed. b) The director of nursing and/or assistant director of nursing will report the findings of the notification of change of status audits to the executive director during daily morning meeting, and to the performance improvement committee for 3 months. c) The performance improvement committee will review the results; and if deemed necessary by the committee, additional education may be provided. The process may be evaluated/revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. d) Performance improvement committee members are the executive director, the medical director, the director of nursing, the assistant director of nursing, the MDS coordinator, the PPS nurse, the rehab services manager, the social services director, the dietary manager, the pharmacist, the maintenance director, the business office manager, the housekeeping supervisor, the staff development coordinator, and the wound care nurse.	5/5/12
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be			

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F 246	Continued From page 2 endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure resident rooms where arranged to accommodate the needs of two residents (#13 & #14) of twenty-five residents reviewed. The findings included: Resident #13 was admitted to the facility on September 15, 2008, with diagnoses including Abnormality of Gait, Diabetes Mellitus, and Muscle Weakness. Medical record review of the resident Minimum Data Set (MDS) dated December 26, 2011, revealed "...Locomotion on unit...limited assistance...resident highly involved in activity..." Observation in the resident's room on March 19, 2012, at 10:50 a.m., revealed resident #13 sitting in a wheelchair. Continued observation at this time revealed the resident was mobile in a wheelchair and unable to get to the other side of the resident's room due to a bed blocking access. Interview with resident #13 on March 19, 2012, at 10:52 a.m., revealed the resident was unable to get to the other side of the room and did not like the bed arrangement. Interview on March 19, 2012, at 1:48 p.m., with the Housekeeping Manager revealed the	F 246	What corrective actions will be accomplished For those residents found to have been affected by the deficient practice: a) On 03/19/12, the housekeeping manager moved resident #13 and # 14's beds to allow for the residents to move about freely in their rooms, and their care plans were updated. b) On 03/19/12, the executive director educated the housekeeping manager on assuring that each resident has the appropriate square footage while also assuring that residents are able to move freely in their rooms. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a) All facility residents have the potential to be affected by this practice. b) On 3/19/12, the housekeeping manager audited all resident rooms. All resident rooms were arranged to provide for the accommodation of each individual resident's needs. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) On 03/19/12, the housekeeping manager educated all housekeepers on assuring that each resident has the appropriate square footage while also assuring that residents are able to move freely in their rooms. b) On 04/18/12 and on 04/20/12, all staff will be educated by the facility executive director to assure that everyone understands the importance of assuring resident rooms are accommodating to the facility's residents.	5/5/12

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F 246	Continued From page 3 resident's bed had been recently moved. Resident #14 was admitted to the facility on March 31, 2008, with diagnoses including Anxiety, Hypertension, and Esophageal Reflux. Observation in the resident's room on March 19, 2012, at 10:34 a.m., revealed resident #14 self ambulating in a wheelchair and unable to get to the other side of the room due to a bed blocking the resident's movement. Interview with the resident and Certified Nursing Assistant (CNA) #1 on March 19, 2012, at 10:36 a.m., in the resident's room, revealed the resident's bed had been recently moved. Continued interview at this time confirmed the resident was able to move freely in the room when the bed did not block access. Interview with the Administrator on March 19, 2012, at 3:20 p.m., in the Administrator office, confirmed the facility failed to ensure that room furniture was arranged to provide for accommodation of needs for resident #13 and #14.	F 246	c) The housekeeping manager will audit resident rooms for resident accommodations weekly for four weeks and monthly for 2 months. How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: a) The housekeeping manager will report the results of the room audits to the performance committee for 3 months. b) The performance improvement committee will review the results; and if deemed necessary by the committee, additional education may be provided. The process may be evaluated/revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. c) Performance improvement committee members are the executive director, the medical director, the director of nursing, the assistant director of nursing, the MDS coordinator, the PPS nurse, the rehab services manager, the social services director, the dietary manager, the pharmacist, the maintenance director, the business office manager, the housekeeping supervisor, the staff development coordinator, and the wound care nurse.	5/5/12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and review of facility policy and procedure, the facility failed to follow a physician's			

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F 281	Continued From page 4 order for two residents (#4 & #12) of twenty-five residents reviewed. The findings included: Resident #4 was admitted to the facility on March 18, 2012, with a diagnosis of a Total Right Hip Replacement. Observation on March 19, 2012, at 10:55 a.m., in the resident's room, revealed an IV (intravenous) device that was capped off for future use. Further observation revealed a date of March 15, 2012, on the IV dressing site. Medical record review of a physician's order, dated March 9, 2012, revealed "...change INT (peripheral IV) site/drsg (dressing) every 72 hr/prn (hours and as needed)..." Review of the facility's policy "Intravenous Therapy", revealed "...transparent dressings are changed aseptically every 48-72 hours at peripheral sites..." Observation and interview with LPN #7, at 11:00 a.m., on March 19, 2012, in the resident's room, confirmed the date on the IV site was March 15, 2012. Further interview confirmed the dressing had not been changed within 72 hours and the facility failed to follow the physician's order. Resident #12 was admitted to the facility on August 30, 2008, with diagnoses including History	F 281	What corrective actions will be accomplished For those residents found to have been affected by the deficient practice: a) On 03/21/12, resident #4's dressing was changed by the charge nurse. b) On 03/20/12, resident #12 received the Vic's Vapor Rub from the charge nurse. c) Charge Nurses were in-serviced on following the facility's physician orders policy and procedure by the staff development coordinator on 03/21/12. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a) All facility residents have the potential to be affected by these practices. b) On 03/22/12, an audit of all residents with IV site dressings was conducted by nursing administration. All dressings were found to be in compliance. c) On 03/21/12, a review of all resident MARS/TARS was completed by nursing administration. No inconsistencies were found. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) On 03/21/12, charge nurses were trained on the facility policy and procedure for following physician orders appropriately by the staff development coordinator. b) On 04/18/12 and on 04/20/12, all licensed nurses will be in-serviced on the facility policy and procedure for following physician orders appropriately by the staff development coordinator.	5/5/12

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F 281	Continued From page 5 of Pulmonary Embolism, Edema, Depressive Disorder, and Anxiety State. Medical record review of a Physician's order dated March 19, 2012, at 4:00 p.m., revealed "...Apply...Vapor Rub as directed as needed...for chest congestion..." Interview with the resident on March 20, 2012, at 8:40 a.m., revealed the resident had not received the medication as requested on March 18, and March 19, 2012. Interview with the Licensed Practical Nurse #7 on March 20, 2012, at 8:45 a.m., on the 300 hall, confirmed the medication was obtained from the back up pharmacy yesterday (March 19, 2012) evening; had not been given as requested by the resident; and the physician's order had not been followed.	F 281	c) Nursing administration will audit MARS/TARS and resident records to ensure physician notification. This audit will be completed weekly for four weeks and monthly for 2 months. How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: a) The director of nursing and/or assistant director of nursing will report the results of the record reviews to the performance improvement committee for three months. b) The performance improvement committee will review the results; and if deemed necessary by the committee, additional education may be provided. The process may be evaluated/revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. c) Performance improvement committee members are the executive director, the medical director, the director of nursing, the assistant director of nursing, the MDS coordinator, the PPS nurse, the rehab services manager, the social services director, the dietary manager, the pharmacist, the maintenance director, the business office manager, the housekeeping supervisor, the staff development coordinator, and the wound care nurse.	5/5/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure falls precautions were in place for one resident (#17) of twenty-five residents reviewed.			

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F 323	Continued From page 6 The findings included: Resident #17 was admitted to the facility on November 2, 2009 with diagnoses including Psychosis, Failure to Thrive, Muscle Weakness, Difficulty Walking, Dementia, Hypertension, Ischemic Heart Disease and Esophageal Reflux. Review of the Minimum Data Set (MDS), dated February 6, 2012, revealed the resident was severely cognitively impaired and required extensive assistance with transfer, bathing and toileting. Observation on March 20, 2012, at 2:10 p.m., in the resident's room, revealed the resident lying in the bed, the bed in the lowest position, two side rails up and no falls mat on the floor. Medical record review of the nurse's notes revealed the resident suffered a fall on February 23, 2012, and March 5, 2012, (with no injuries). Further review of the Care Plan, dated February 23, 2012, revealed "...floor mat at bedside..." Medical record review of a physician's order, dated February 23, 2012, revealed "...add floor mat at bedside...". Further review of the facility's investigation report, dated March 5, 2012, revealed "...floor mat added..." Observation and interview with the facility Administrator on March 21, 2012, at 10:15 a.m., in the resident's room, confirmed the floor mat was not at the resident's bedside, the facility failed to follow the physician's order; and failed to ensure fall precautions were in place for the	F 323	What corrective actions will be accomplished For those residents found to have been affected by the deficient practice: a) On 03/21/12, resident #17's fall mat was placed at bedside by the central supply clerk. b) On 03/21/12, the charge nurse and certified nursing assistants were in-serviced on proper review of the resident care guide to ensure that fall precautions are in place by the staff development coordinator. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a) Residents with fall precautions have the potential to be affected by these practices. b) On 03/21/12, all residents with physician ordered fall interventions were audited for appropriate placement by nursing administration. All interventions were found to be in place. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) On 03/21/12, licensed nurses and certified nursing assistants were educated by the staff development coordinator on the importance of reviewing the resident care guides to ensure resident's fall interventions are in place. b) On 04/18/12 and on 04/20/12, all staff will be in-serviced by the staff development coordinator on the importance of ensuring that resident's fall interventions are in place and the importance of by reviewing the resident care guide for this information.	5/5/12

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F 323 F 431 SS=E	Continued From page 7 resident. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 323	c) Nursing administration will audit residents with falls interventions to ensure they are in place weekly for four weeks and monthly for 2 months. How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: a) The director of nursing and/or assistant director of nursing will report the results of the resident's fall intervention audits to the performance improvement committee for three months. b) The performance improvement committee will review the results; and if deemed necessary by the committee, additional education may be provided. The process may be evaluated/revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. c) Performance improvement committee members are the executive director, the medical director, the director of nursing, the assistant director of nursing, the MDS coordinator, the PPS nurse, the rehab services manager, the social services director, the dietary manager, the pharmacist, the maintenance director, the business office manager, the housekeeping supervisor, the staff development coordinator, and the wound care nurse.	5/5/12

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F 431	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility's policy, review of Tennessee Pharmacy Laws 2011 Edition, and interview, the facility failed to secure the contents of emergency medications for residents in three (North Hall First Dose Orange Emergency Box CE 61, North Hall First Dose Blue Intravenous [IV] Emergency Box, South/West Halls First Dose Orange Emergency Box CE 08) of five emergency boxes observed in two (North Hall Medication Room, South/West Halls Medication Room) of two medication rooms observed, and failed to provide documentation of a signature of receipt for control substances released on leave of absence for one (#21) of twenty-five sampled residents reviewed. The findings included: Unsecured Emergency Boxes North Hall Medication Room Observation of the First Dose Orange Emergency Box CE 61 on March 19, 2012, at 10:50 a.m, in the North Hall Medication Room, with Licensed Practical Nurse (LPN) #1 revealed the box was unlocked. Further observation of the list of contents on the outside of the box revealed 906 units of 151 medications requiring physician orders were available for emergency use for residents. The list included antibiotic medications (Amoxicillin); medications for blood pressure (Atenolol); antipsychotic medications (Quetiapine); diabetic medications (Glipizide); and blood thinner medications (Warfarin). Review of the facility's policy, "Emergency Drug	F 431	What corrective actions will be accomplished For those residents found to have been affected by the deficient practice: a) No residents were affected by this deficient practice. b) On 03/20/12, all emergency boxes were locked and the contents were secured by the charge nurses. c) On 03/21/12, licensed practical nurse #3 was educated by the director of nursing on the importance of ensuring the "Release of Responsibility for Medication" form is completed at the time of a resident's leave of absence from the facility. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a) Residents needing medications while on leave of absence from the facility have the potential to be affected by this deficient practice. b) On 03/20/12, all residents' records that take a leave of absence from the facility were reviewed for "Release of Responsibility for Medication" form compliance. All other resident records were complete. c) On 03/20/12, the charge nurses reviewed all emergency boxes to ensure they were locked and secure. All emergency boxes were found to be locked and secure.	5/5/12

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F 431	Continued From page 9 Box" revealed, "...Standard...Medications needed for emergency care are kept secure...in the emergency drug box..." Review of the Tennessee Pharmacy Laws 2011 Edition Rule 1140-4-.09 "EMERGENCY AND HOME CARE KITS" (page 210) documented "... (3) The emergency kit shall be provided sealed or electronically secured by authorized personnel in accordance with established policies..." Interview with LPN #1 on March 19, 2012, at 10:55 a.m., in the North Hall Medication Room, confirmed the emergency box was unlocked, and the contents were not secured per facility's policy. Interview with the Pharmacy Consultant, by telephone, on March 20, 2012, at 3:00 p.m., in the Administrator's Office confirmed emergency boxes are to be secured at all times per facility's policy. Observation of the First Dose Blue IV Emergency Box on March 19, 2012, at 10:50 a.m., in the North Hall Medication Room, with LPN #1 revealed the box was unlocked. Further observation of the list of contents on the outside of the box revealed 23 bags of IV fluids requiring physician orders were available for emergency use for residents. The list included Dextrose 5% with Water 1000 milliliters (ml) and Normal Saline 0.9% 1000 mls. Review of the facility's policy, "Emergency Drug Box" revealed, "...Standard...Medications needed for emergency care are kept secure...in the emergency drug box..." Review of the Tennessee Pharmacy Laws 2011	F 431	What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) On 03/20/12, licensed nurses were in-serviced by the director of nursing on the importance of following the policy and procedure of ensuring emergency boxes are locked and secure. b) On 03/20/12, licensed nurses were in-serviced on the importance of following the policy and procedure of ensuring the "Release of "Responsibility for Medication" form is completed at the time of a resident's leave of absence from the facility by the staff development coordinator. d) On 04/18/12 and on 04/20/12, all licensed nurses will be in-serviced by the staff development coordinator on ensuring emergency boxes are locked and secure and on ensuring the "Release of Responsibility for Medication" form is completed at the time of a resident's leave of absence. e) The director of nursing and/or assistant director of nursing will audit MARS/TARS to ensure that residents on a leave of absence that need medication are done in accordance with Life Care Center's policy and procedures weekly for 4 weeks and monthly for 2 months. f) The director of nursing and/or assistant director of nursing will audit emergency boxes to ensure they are locked and secure weekly for 4 weeks and monthly for 2 months.	5/5/12

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	445302	A. BUILDING _____ B. WING _____	03/21/2012

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F 431	Continued From page 10 Edition Rule 1140-4-.09 "EMERGENCY AND HOME CARE KITS" (page 210) revealed "...(3) The emergency kit shall be provided sealed or electronically secured by authorized personnel in accordance with established policies..." Interview with LPN #1 on March 19, 2012, at 10:55 a.m., in the North Hall Medication Room, confirmed the emergency box was unlocked, and the contents were not secured per facility's policy. Interview with the Pharmacy Consultant, by telephone, on March 20, 2012, at 3:00 p.m., in the Administrator's Office, confirmed emergency boxes are to be secured at all times per facility's policy. South/West Halls Medication Room Observation of the First Dose Orange Emergency Box CE 08 on March 20, 2012, at 8:55 a.m., in the South/West Halls Medication Room, with LPN #2 revealed the box was unlocked. Further observation of the list of contents on the outside of the box revealed 906 units of 151 medications requiring physician orders were available for emergency use for residents. The list included antibiotic medications (Amoxicillin); medications for blood pressure (Atenolol); antipsychotic medications (Quetiapine); diabetic medications (Glipizide); and blood thinner medications (Warfarin). Review of the facility's policy, "Emergency Drug Box" revealed, "...Standard...Medications needed for emergency care are kept secure...in the emergency drug box..." Review of the Tennessee Pharmacy Laws 2011	F 431	How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: a) The director of nursing and/or assistant director of nursing will report the results of the emergency box audits and the completion of the "Release of Responsibility for Medication" form audits to the performance improvement committee for three months. c) The performance improvement committee will review the results; and if deemed necessary by the committee, additional education may be provided. The process may be evaluated/revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. d) Performance improvement committee members are the executive director, the medical director, the director of nursing, the assistant director of nursing, the MDS coordinator, the PPS nurse, the rehab services manager, the social services director, the dietary manager, the pharmacist, the maintenance director, the business office manager, the housekeeping supervisor, the staff development coordinator, and the wound care nurse.	5/5/12

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F 431	Continued From page 11 Edition Rule 1140-4-.09 "EMERGENCY AND HOME CARE KITS" (page 210) revealed "...(3) The emergency kit shall be provided sealed or electronically secured by authorized personnel in accordance with established policies..." Interview with LPN #2 on March 20, 2012, at 8:56 a.m., in the South/West Halls Medication Room, confirmed the emergency box was unlocked, and the contents were not secured per facility's policy. Interview with the Pharmacy Consultant, by telephone, on March 20, 2012, at 3:00 p.m., in the Administrator's office confirmed emergency boxes are to be secured at all times per facility's policy. Controlled Substance Medications for Leave of Absence Medical record review of the "INDIVIDUAL PATIENT'S CONTROLLED SUBSTANCES RECORD" for Alprazolam 0.25 milligram (mg) tablet for Resident #21 on March 19, 2012, at 1:25 p.m., at the North 2 Medication Cart with LPN #6 revealed three Alprazolam 0.25 mg tablets were signed out as "Sent home with Family" on March 17, 2012, at 11 a.m., by LPN #3. Alprazolam (Xanax) is a controlled substance medication prescribed for anxiety. Further review revealed the absence of a "RELEASE OF RESPONSIBILITY FOR MEDICATION" form documenting the three Alprazolam 0.25mg tablets for the leave of absence were signed out as received by a family member. Medical record review of the March 2012, physician's recapitulation orders signed and	F 431		

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F 431	Continued From page 12 dated by the physician on March 6, 2012, revealed an order for "...ALPRAZOLAM 0.25MG TABLET...TAKE 1 TAB (tablet) BY MOUTH THREE TIMES DAILY - ANXIETY..." Medical record review of the facility's "RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE" form revealed the brother of Resident #21 signed Resident #21 out of the facility on March 17, 2012, at 11:15 a.m., and returned Resident #21 to the facility on March 18, 2012, at 2:45 p.m. Interview with the LPN #6 on March 19, 2012, at 1:30 p.m., at the North 2 Medication Cart in the North Hall Nursing Station confirmed the absence of a "RELEASE OF RESPONSIBILITY FOR MEDICATION" form documenting the three Alprazolam 0.25mg tablets for the leave of absence were signed out as received by a family member. Interview with the Interim Director of Nursing (DON) and the Administrator on March 20, 2012, at 2:30 p.m., in the Administrator's Office, confirmed the absence of a facility's "RELEASE OF RESPONSIBILITY FOR MEDICATION" form in the medical record documenting the three Alprazolam 0.25mg tablets were signed out as received by a family member and the facility's policy for a leave of absence was not followed. Interview with LPN #3, by telephone, with the Administrator, on March 20, 2012, at 2:45 p.m., in the Administrator's Office, confirmed three Alprazolam 0.25 mg tablets for the leave of absence were released to the brother of Resident #21 without the documentation of a signature of	F 431		

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F 431	Continued From page 13 receipt and LPN #3 was aware of the facility's "RELEASE OF RESPONSIBILITY FOR MEDICATION" form and the facility's policy for leave of absence but "completely forgot" to follow it. F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	What corrective actions will be accomplished For those residents found to have been affected by the deficient practice: a) On 3/19/12, resident #1's catheter bag was changed by the charge nurse. b) On 03/19/12, licensed nurses and certified nursing assistants were in-serviced on the importance of ensuring a safe, sanitary, and comfortable environment to help prevent transmission of disease and infection related to catheter care by the staff development coordinator. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a) Residents with catheters have the potential to be affected by this deficient practice. b) On 03/19/12, nursing administration reviewed all residents with catheters to ensure a safe, sanitary, and comfortable environment was being maintained. All catheters were being appropriately managed to prevent the transmission of disease and infection. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a) On 03/19/12, licensed nurses and certified nursing assistants were in-serviced on the importance of ensuring a safe, sanitary, and comfortable environment to help prevent transmission of disease and infection related to catheter care by the staff development coordinator.	5/5/12

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F 441	Continued From page 14 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure infection control strategies were maintained for a urinary catheter for one resident (#1) of twenty-five residents reviewed. The findings included: Resident #1 was admitted to the facility on December 12, 2008, with diagnoses including Dementia, Osteoporosis, Congestive Heart Failure, Psychosis, and Anemia. Medical record review of a Physician's Order dated February 22, 2012, revealed,"...(Urinary) Cath (Catheter)...d/t (Diagnosis) MRSA (Methicillin Resistant Staphylococcus Aureus) in urine." Observation on March 19, 2012, at 10:55 a.m., in the resident's room, revealed the resident lying in bed with a urinary catheter to bed side drainage. Continued observation revealed the exit port of the catheter was touching the floor. Interview with Licensed Practical Nurse #4 on March 19, 2012, at 10:59 a.m., in the resident's room, confirmed the exit port of the catheter was touching the floor and the facility had failed to	F 441	b) On 04/18/12 and on 04/20/12, all licensed nurses will be in-serviced by the staff development coordinator on ensuring a safe, sanitary, and comfortable environment to help prevent transmission of disease and infection related to catheter care by the staff development coordinator. c) The director of nursing and/or assistant director of nursing will audit residents with catheters/infection control procedures throughout the facility weekly for 4 weeks and monthly for 2 months. How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: a) The director of nursing and/or assistant director of nursing will report the results of the catheter/infection control procedure audits to the performance improvement committee for three months. b) The performance improvement committee will review the results; and if deemed necessary by the committee, additional education may be provided. The process may be evaluated/revised and/or the audits reviewed for 3 months or until 100% compliance is achieved. c) Performance improvement committee members are the executive director, the medical director, the director of nursing, the assistant director of nursing, the MDS coordinator, the PPS nurse, the rehab services manager, the social services director, the dietary manager, the pharmacist, the maintenance director, the business office manager, the housekeeping supervisor, the staff development coordinator, and the wound care nurse.	5/5/12

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F 441	Continued From page 15 maintain infection control strategies to prevent a source of infection.	F 441		